PRINTED: 07/14/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 09G056 07/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW **COMP CARE II** WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) W 000 **INITIAL COMMENTS** W 000 A re-certification survey was conducted from June 30, 2009, through July 1, 2009. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a client population of five males THE DISTRICT OF COLUMBIA with various disabilities. DEPARTMENT OF HEALTH **HEALTH REGULATION ADMINISTRATION** The findings of the survey were based on 825 NORTH CAPITOL ST., N.E., 2ND FLOOR observations at the group home and three day **WASHINGTON, D.C. 20002** programs, interviews with management and staff. and the review of administrative records, including the facility's incident management system. W 104 483.410(a)(1) GOVERNING BODY W 104 The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the governing body failed to exercise general policy and operating direction over the facility for five of the five clients residing in the facility. (Client's #1 - #5) The findings include: 1. Cross refer to W331. The facility's governing body failed to an effective monitoring system to W 104.1 ensure that outside services administered Client #3's prescribed medications. **Cross Reference W 331**

committee prior to the implementation of such

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

2. Cross refer to W262. The facility's governing

body failed to ensure that restrictive measures were reviewed and approved by the HRC

Admin strates

W 104.2

Cross Reference W 262

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		IDENTIFICATION NUMBER:	A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	
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	AME OF PROVIDER OR SUPPLIER COMP CARE II SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 104 Continued From page 1 measures for all five residents residing in the facility. (Clients #1, #2, #3, #4, and #5) 483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to maintain client's rights and/or ensure each client was encouraged to exercise their rights, for one of five clients residing in the facility (Clients #4) The finding includes: [Cross Refer W262] Interview with the Residentia Director (RD) on the June 30, 2009 at approximately 11:00 AM, revealed that the facility had door alarms on the second and third level		STREET ADDRESS, CITY, STATE, ZIP COI 1321 EMERSON STREET NW WASHINGTON, DC 20011		101/2009	
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 104	Continued From pa	nge 1	W 10)4		
W 125	facility. (Clients #1, 483.420(a)(3) PRO	#2, #3, #4, and #5)	W 12			
	Therefore, the facili individual clients to of the facility, and a including the right to	ty must allow and encourage exercise their rights as clients s citizens of the United States,				
	Based on interview failed to maintain cli each client was end rights, for one of five	and record review, the facility ient's rights and/or ensure couraged to exercise their	÷			,
	The finding includes	s:		W 125		,
	Director (RD) on the approximately 11:00 had door alarms on rear exit doors. According to walk away from the Review of the Huma minutes on the same evidence that the dopresented to the cor	e June 30, 2009 at 20 AM, revealed that the facility the second and third level cording to the RD the alarms ecause Client #4 was known he facility. In Rights Committee (HRC) e day at 1:55 PM did not		The use of the door ala be presented to the Hu Rights Committee (HR review. The families and/or gu of the five clients shall informed of the use of alarms on the second a level exit rear doors. C for the use of the alarm be sought.	man (C) for ardians be the door ind third onsent as shall	
		was no evidence that the presentatives for any of the			08/30/09	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	DITIPLE CONSTRUCTION DING	(X3) DATE : COMPL	
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COMP C	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1321 EMERSON STREET NW WASHINGTON, DC 20011		
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W 125	Continued From pa	ge 2	W 12	25		
W 149	clients had been no use of the door alar 483.420(d)(1) STAF CLIENTS		W 14			
	policies and proced	velop and implement written ures that prohibit ct or abuse of the client.				
	Based on observation review, the facility fairnplement policies to	on not met as evidenced by: on, interview and record illed to establish and/or hat ensured the client's health of the five clients that resided #2)			\$	
	The finding includes	:				
	The facility failed to its "Incident Manage below:	ensure the implementation of ment" policy as outlined				
	interview with the Re record review at Clie a "Health Concern C	pproximately 12:40 PM, egistered Nurse (RN) and nt #2's day program revealed ommunique" (HCC) was tial facility on June 4, 2009. ne following details:				
	had an open wound percolate - area was non-adhesive dry [gu	ed his right foot lateral area draining serosanguineous cleaned with normal saline & laze] applied/taped securely. he fell the other day at				
		cility's Qualified Mental conal (QMRP) on July 1, 2009				

		AND HUMAN SERVICES			FORM	D: 07/14/2009 M APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) M	MULTIPLE CONSTRUCTION	(X3) DATE	
AIND FLAIN	OF CORRECTION	IDENTIFICATION NUMBER:	1	ILDING	- COMPI	LETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	at 4:00 PM, revealed #2 sustained the injurevealed that an include after he received no program of the client Record review at the same day at approximate document entitled "Reporting Procedure DDS" that provided unusual incidents. A agency policy was to Additionally, the informational policy was necessary, the Section C describes complete an incident rethe agency administre the agency administre client #2's injury which program in accordant management policy. 483.420(d)(2) STAFF CLIENTS The facility must ensist reatment, neglecting in the additional policy. The facility must ensist reatment, neglecting in the additional policy.	d he did not know how Client cury. Further interview ident report was not written tification from the day it's injury. The residential facility on the imately 4:10 PM, revealed a necident Handling and es for Persons Served by guidance on how to manage according to the QMRP, the ouse these procedures. It is the proceed to section A uation provides for the in: If the threatening, apply first then proceed to section C." It is the agency must then the report. The report was generated to notify ator and other officials of the characteristic of the country in the agency's incident of the country incident. The TREATMENT OF the country is the proceed in the agency is incident in the agency in the agency is incident	W 15	W 149 The Qualified Mener Retardation Profess (QMRP) will on a weak basis review "Healt Communique (HCC) day programs to entincident reports are injuries of unknown an investigation contrained on incident management policie procedures.	tal sional veekly th Concern C)" from sure that written for n origin and npleted. will be	

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program of the client's injury.

at 4:00 PM revealed he did not know how Client #2 sustained the injury. Further interview revealed that an incident report was not written after he received notification from the day

At the time of the survey, the facility failed to ensure an incident report was generated to notify

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percolate - area was cleaned with normal saline & non-adhesive dry [guaze] applied/taped securely.

[Client #2] stated he 'fell the other day at home'."

Interview with the facility's Qualified Mental Retardation Professional (QMRP) on July 1, 2009 at 4:01 PM revealed he did not know how Client W 154

Cross Reference W 149

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPL LDI N G	LE CONSTRUCTION	(X3) DATE SI COMPLE	
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	#2 sustained the injinvestigation to determine the injury after he reday program. At the time of the suinitiate an investigat Client #2's injury who program. 483.430(a) QUALIF RETARDATION PREACH Client's active integrated, coordinate qualified mental retained and investigated mental retained and investigated in the second ensure integration, colient's active treatment three client's in the second in the	ury and did not initiate an armine the possible causes of eceived notification from the arrow, the facility failed to ion to determine the cause of ich was discovered by the day IED MENTAL OFESSIONAL areatment program must be ted and monitored by a ardation professional. In not met as evidenced by: ons, interviews with the tardation Professional review, the QMRP failed to coordination and monitoring of tent regimen for two of the sample. (Client #1 and #3) In tal Retardation Professional sure recommended behavior porated into Client #3's day of address his maladaptive	W 1		DEFICIENCY)		
	interview with the da revealed that Client a day program on May twice in his classrool	approximately 11:15 AM, y program case manager #3 was sent home from the 27, 2009 for throwing a chair m. According to the case of a new behavior. Further					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ULTIPLE CONSTRUCTION LDING	(X3) DATE S COMPL	
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	interview with the direvealed that on Jurchair on three separe attacked the receptifurther commented client was sent home. Interview with the fact 4:00 PM, revealed aforementioned incited had several other action and several other action at the staff decline is not to bad". b. February 11, 200 program staff decline is not to bad". b. February 11, 200 program staff sright was taken to the day assessment and take emergency room for action at the section at the section and section at the section a	ay program coordinator ne 29, 2009, Client #3 threw a grate occasions and physically itonist. The case manager that on both of these days the ne from the day program. acility's QMRP on July 1, 2009 and he was aware of the idents, further stating Client #3 ggressive outburst at his day aff sustained injuries. The ollows: 2008, Client #3 threw a chair at aff and hit her in the breast. aff was directed to consult the of her injury. The nurse staff to the emergency room and and commented "The pain" 29, Client #3 grabbed a day arm and bit her. The staff y program nurse for an initial ten to Providence Hospital further treatment. 29, the staff is released from work early to on due to persistent head	W 15	W 159.1 a, b, c On July 6, 2009 the Mental Retardation Professional (QMI case conference will day program on the completing the one request package. That been complete forwarded to MAA after an Interdiscip Team (IDT) meetin August 1st, 20009.	on RP) held a ith client #1's he subject of e-on-one The package d and will be A and DDS plinary	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE S COMPLE	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	outbursts. Reported team reached a corneed of "one on one safety. The recommereral package too services for Client # forwarded to the result of Client #3's record Disabilities Services 2009 that stated the "DDS visited the day concerns of Client # behavior and noted program will discuss the residence for DDSC will like to have a attorney to discuss the residence for DDSC will contact the has an advocate to a had an incident when from the day program. On the same day at review of Client #3's Plan dated August 2 targeted behaviors in involves forcefully methem without appared damage to property of physical aggression punching). At the time of the surthat a referral package to the same day at the time of the surthat a referral package to the surt	dly in this case conference the isensus that the client was in e" services for Client #3's mendation included putting a gether requesting one on one is and the package was to be sidential provider for approval. Approximately 1:30 PM, review is revealed a Department of (DDS) note dated May 29,	W :	59			
	THE CHANGE WHEN SUDII	inted to DDS and MAA to					

PRINTED: 07/14/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 09G056 07/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1321 EMERSON STREET NW COMP CARE II** WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) W 159 Continued From page 9 W 159 secure the IDT team's recommendation for one on one services at his day program. W 159.3 3. The QMRP failed to ensure that staff received Cross Reference W 189 initial and continuing training to each employee to enable them to perform duties effectively. efficiently and competently. [See W189] 4. The QMRP failed to ensure the implementation W 159.4 of an effective system of documenting a client's Cross Reference W 252 progress on his program objectives. [See W252] W 189 483.430(e)(1) STAFF TRAINING PROGRAM W 189 The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently for two of the three clients in the sample. (Client's #1, #3)

The findings include:

- 1. The facility failed to ensure staff were trained to effectively document Client #1's exercise objectives in accordance with his Individual Program Plan (IPP). (See W252)
- 2. The facility failed to ensure that all staff who provide direct support to Client #3 was trained in Crisis Prevention Techniques in accordance with his behavior support plan.

W 189.1

Staff will be in-serviced on effective documentation of client's progress regarding program objectives. The House Manager will on a weekly basis review the program books to ensure proper and effective documentation.

The QMRP will on a quarterly basis or as needed in-service staff on the subject of effective data collection.

08/19/09

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incidents were as follows:

- b. February 11, 2009, Client #3 grabbed a day program staff's right arm and bit her. The staff was taken to the day program nurse for an initial assessment and taken to Providence Hospital emergency room for further treatment.
- c. April 7, 2009, Client #3 punched a day program staff person in her right eye. The staff who was injured was released from work early to seek medical attention due to persistent head pain.

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#3.

day at approximately 3:20 PM, did not evidence Crisis Intervention Techniques strategies training was provided to the residential staff and/or the day treatment staff who routinely work with Client

At the time of survey, there was no evidence the

		AND HUMAN SERVICES MEDICAID SERVICES		٠		FORM	D: 07/14/2009 M APPROVED
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W 189	facility had ensure the area of Crisis Preventer techniques in accordensure his safety. 3. The facility failed effectively trained to of food in accordance. On June 30, 2009 at Client #3 was offered of shredded beef, much broccoli. Client #3 man repeatedly ask him to food. He continued repeatedly requested the was not allowed to the was not allowed to the was not allowed to the pust on the couch and commented, "We will into the refrigerator at the couch and commented, "We will into the refrigerator at the couch and commented, "We will into the refrigerator at the same food it previous evening. In Director (RD) confirm the microwave belongstated that she would staff to find out why of dinner. Later interview on the approximately 2:45 P	to ensure that staff was document Client #3's PM, dhis dinner which consisted ash potatoes with gravy and efused to eat his to refuse. Client #3'd "cheese and hot dogs". Ed him and informed him that to eat cheese and hot dogs.	W	189	W 189.2 Staff were trained on Cri Prevention Techniques (e) on July 14 and 15. Their cards will be mailed to the residential provider in the four weeks. 08/36	CPI) CPI te tree to	

PRINTED: 07/14/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G056 07/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW **COMP CARE II** WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 189 Continued From page 13 W 189 could not be determine the type of sandwich that was provided. W 189.3 On the same day at 3:15 PM, review of Client #3's mealtime protocol dated December 3, 2008 The nutritionist will train staff revealed, staff are to "document Client #3's refusal to eat food presented and report to on how to effectively document medical personnel and the QMRP of the food refusals and substitutes. residential facility". The House Manager (HM) will Review of the client records did not evidence that staff documented the client's continued refusal on weekly basis work with and the substitution provided. It should be noted

W 252

483.440(e)(1) PROGRAM DOCUMENTATION

that review of Client #3's nutritional assessment

dated December 29, 2008 failed to include a list

According to the QMRP, staff were trained on the clients mealtime protocols by the nutritionist back on October 10, 2008. At the time of this survey, there was no evidence that this training was

of the client's food preference with appropriate

substitutions for the staff's usage when he

refuses his meals.

effective.

Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.

This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the implementation of an effective system of documenting a client's progress on his program objectives for one of the three client's in the sample. (Clients #1)

The House Manager (HM) will on weekly basis work with staff in ensuring that the food substitute list is efficiently utilized and food substitutes consistently documented.

08/19/09

W 252

PRINTED: 07/14/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 09G056 07/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW **COMP CARE II** WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) W 252 Continued From page 14 W 252 The finding includes: The facility failed to ensure that direct care staff collected consistent data on Client #1's exercise objective in accordance with the individual program plan. On July 1, 2009 at approximately 2:00 PM. interview with the Qualified Mental Retardation W 252 Professional (QMRP) and record review revealed that Client #1 has an individual program objective The nutritionist will provide to enhance his physical fitness. The objective food preference and substitute states that "Client #1 will ride the stationary bike lists for client #3. for 5 minutes per session for three consecutive trials on 60% of the recorded trials. The nutritionist will train staff Review of the data for the month of June 2009 on how to effectively utilize revealed that data was not collected on the 2nd. and document the food 16th and the 23rd. According to the QMRP, the preference list and utilization frequency of this objective was three times a week and the data was to have been collected at of the substitute lists. that time. Reportedly, in-service training occured on Janaury 15, 2009 and April 15, 2009. 08/19/09 At the time of the survey, there was no evidence that this objective was being implemented and recorded consistently. W 262 483.440(f)(3)(i) PROGRAM MONITORING & W 262 **CHANGE** The committee should review, approve, and

client protection and rights.

monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to

This STANDARD is not met as evidenced by:

PRINTED: 07/14/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 09G056 07/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW COMP CARE II WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **TAG** CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 262 Continued From page 15 W 262 Based on observation, staff interview and record review, the facility failed to ensure programs that incorporate restrictive techniques had been reviewed, approved and monitored by its specially constituted committee prior to implementation, for five of the five clients residing in the facility. (Client #1, #2, #3, #4 and #5) The findings include: Observation in the group home on June 30, 2009 at approximately 3:40 PM, revealed Client #4 was observed to exit the group home from the second level rear door unsupervised. Observation on July 1, 2009 at approximately 3:15 PM, on a second occasion, Client #4 was observed to open the basement door and exit the facility into the back yard unsupervised. On the first occasion. Client #4 was only moments later observed by the staff and redirected by the staff to return into the facility. Client #4 responded without incident and walked back into the facility. On the second occasion, the surveyor alerted the nurse that Client #4 was walking out the basement door leading out to the back yard. Interview with the Residential Director (RD) on the June 30, 2009 at approximately 11:00 AM.

revealed that the facility has door alarms on the second and third level rear exit doors. Further interview with the RD revealed that the rear door alarm on the second level near the kitchen was

disconnected. However, the RD further commented that the third floor alarm remained activated. According to the RD the alarms were on the doors because "Client #4 was known to

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	walk away from the On July 1, 2009 at 3 Qualified Mental Re (QMRP), the RD, an via telephone revea main level had been According to the QM door alarms be shut commented that the been presented to the and approved for us Administrative Assis Owner/CEO was aw	facility". 8:50 PM, interview with the tardation Professional difference the Administrative Assistant led, the door alarm on the recently deactivated. IRP, he had requested that all off. The QMRP further use of the alarms had not ne Human Rights Committee e. Further interview with the tant revealed that the rare of the use of these	W 262	W 262 The facility is collecting baseline data on client behavior of attempting elope. Such data will be presented to the psychofor assessment. The use of door alarms presented to the HRC f	#4 to clogist will be	
	alarms were a prote each clients safety. the QMRP, Client #4 the facility unsupervihad not been assess Review of the agence evidenced that the falarms had been preHRC prior to their us	y's HRC minutes did not acility's use of the door sented and approved by the age.		review.	19/09	
-	483.460(a)(3) PHYS The facility must pro- general medical care	vide or obtain preventive and	W 322			
t	Based on observation review the facility's fa	not met as evidenced by: n, staff interview, and record illed to provide preventative one of the three Client's in			,	

PRINTED: 07/14/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING_ 09G056 07/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1321 EMERSON STREET NW** COMP CARE II WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 322 Continued From page 17 W 322 W 322 The facility failed to provide oversight to ensure Please refer to W 331.2 and that Client #3 was administered his medications W369 as prescribed. (See W331 and W369) W 331 483.460(c) NURSING SERVICES W 331 The facility must provide clients with nursing services in accordance with their needs This STANDARD is not met as evidenced by: Based on interviews and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs for two of three clients in the sample. (Client #1 and Client #3) The findings include: Cross Refer to W369. The facility's nurses failed to ensure that their system for drug administration assured that all drugs are W 331. 1 administered without error. Please refer to W369. 2. The facility's nursing staff failed to ensure that Client #3 received his noon dosage of medication when absent from his day program as evidenced below: On June 30, 2009 at approximately 1:40 PM, interview with the day program nurse revealed that Client #3 receives Tegretol 300 mg at noon.

June. 2009.

Further interview with the day program nurse confirmed the client was absent several days from the day program for the months of May and

Interview on July 1, 2009 at 2:45 PM with the

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SURVEY COMPLETED

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W 369	facility's nurse verifications age of Tegretol interview with the nursystem had been est was administered his Tegretol when not at the month of May 20 from the program or May MAR from the gon either of these data administered his not Further review of the revealed that Client is program on the 4th at June MAR's for the gon either of these data administered his not program on the 4th at June MAR's for the gon either of these data administered his not prescribed. At the time of the surestablish an effective ensure Client #3 was dosage of Tegretol at 483.460(k)(2) DRUG. The system for drug that all drugs, including self-administered, are This STANDARD is Based on observation verification, the facility system for drug administered for drug a	ed Client #3 received a noon at his day program. Further are did not evidence a clear stablished to ensure the client is prescribed noon dosage of ttending his day program. 3:00 PM, review of the ration Record (MAR) ay program revealed that for 109, Client #3 was absent in 6th and 21st. Review of the proup home, did not verify that ays the client was not	W 3		W 331.2 On any day client #3 is absfrom his day program, the facility nurse will pick up noon meds from the day program and administer that home. The facility will on a mont basis review the MAR from the day program to ensure client #3 is receiving his medicines as prescribed. 08/19/	the hem hly n that	

PRINTED: 07/14/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 09G056 07/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW COMP CARE II WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 369 Continued From page 19 W 369 three clients in the sample. (Client #1 and Client The findings include: 1. Observation of the medication pass on June 30, 2009 at approximately 7:55 AM revealed Licensed Practical Nurse #1 (LPN) did not administer Nasonex nasal spray to Client #3 at the time of the medication pass. W 369.1 The facility's Registered Nurse Review of the June 2009 Medication (RN) will in-service the Administration Record (MAR) and physician's **Licensed Practical Nurses** orders (POS) dated June, 2009 on June 30, 2009 at approximately 8:25 AM revealed Client #3 was (LPNs) on the principles of ordered Nasonex nasal spray; two(2) sprays in medication administration. each nostril every day. The RN will once quarterly In an interview with LPN #1 on June 30, 2009 at observe the LPNs during meds approximately 8:35 AM, it was acknowledged pass so as to ensure Client #3 was to have been administered Nasonex nasal spray; two(2) sprays in each compliance. nostril every day. 08/19/09 There was no evidence that all drugs were administered without error. [Note: LPN #1 administered Client #3's Nasonex nasal spray; two(2) sprays in each nostril on June 30, 2009 at approximately 8:40 AM after the surveyor revealed the medication error.] 2. Observation of the medication pass on June

30, 2009 at approximately 8:20 AM revealed that LPN #1 did not administer Nasonex nasal spray to Client #1 at the time of the medication pass.

Review of the MAR dated June, 2009 and the POS dated June, 2009 on June 30, 2009 at

PRINTED: 07/14/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 09G056 07/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1321 EMERSON STREET NW** COMP CARE II WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) W 369 Continued From page 20 W 369 approximately 8:27 AM, revealed Client #1 was ordered Nasonex nasal spray; two(2) sprays in each nostril every day. In an interview with LPN #1 on June 30, 2009 at approximately 8:36 AM, it was acknowledged Client #1 was to have been administered Nasonex nasal spray; two(2) sprays in each nostril every day. W 369.2 There was no evidence that all drugs were Cross Reference W 369.1 administered without error. [Note: LPN #1 administered Client #1's Nasonex nasal spray; two(2) sprays in each nostril on June 30, 2009 at approximately 8:42 AM after the surveyor revealed the medication error.] W 474 483.480(b)(2)(iii) MEAL SERVICES W 474 Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure client's received their meal(s) in the form and consistency as required for one of three clients in the sample. (Client #2) The finding includes: The facility failed to ensure that Client #2 was provided his prescribed diet as evidenced below:

shredded beef for their dinner.

Observation on June 30, 2009 at approximately 6:00 PM revealed, all five Clients residing in the facility was served the same textured portions of

		AND HUMAN SERVICES				FORM	: 07/14/2009 APPROVED
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W 474	Continued From page	ge 21	W 4	174			
	Retardation Profess review on July 1, 20 revealed Client #2's March 29,2009 reco "Regular diet, no ad" Further record review Speech Pathology a 2009 detailed the fol "[Client #2] is prescr consistency Direct [Client #2] support, a needed to ensure sa intake. This decreas experiencing choking related illnesses. "	cility's Qualified Mental ional (QMRP)and record 09 at approximately 3:30 PM Nutritional assessment dated mmended the following: ded salts, chopped texture". w revealed Client #2's ssessment dated April 30, lowing mealtime observation: ibed a regular diet texture t care program staff provides assistance and supervision as ife and adequate dietary ses the likelihood of him g, aspiration or aspiration					
	current physician's or provided for a texture. According to both the QMRP on July 1, 200 Client #2's foods sho "finely chopped" texture previous night. There was no evident effort to clarify the food There was also no excoordinated with the leathologist and Primastaff provided his food	ce that the facility made any od texture for Client #2. ridence that the QMRP Nutritionist, the Speech ary care physician to ensure			W 474 Client #2's diet texture habeen clarified to be chopp instead of finely chopped. are adhering to the currendiet texture. The QMRP will on a monbasis review the clients' records to ensure that recommendations are consistent across disciplin 07/22	ed, Staff it thly es.	

If continuation sheet 1 of 15

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDIN		(X3) DATE S COMPL	
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1 000	INITIAL COMMEN	тѕ		1 000			
	30, 2009, through a sample of three resident population disabilities. The findings of the observations at the programs, interview and the review of a	rey was conducted from July 1, 2009. A random sidents was selected to of five males with values with values with ward was with management and instrative records yes incident management.	om from a irious in ee day and staff,				
	Each GHMRP shal preparation and se care of equipment,	RVICE / DINING ARE I train staff in the store rving of food, the cleated and food preparation of conditions at all time	age, ining and in order	I 056			
	Based on staff inter GHMRP failed to er meals received their	met as evidenced by: view and record reviensure staff who prepa ir food handler's certif taff records reviewed	ew, the ired fication		I 056 The facility will scheetwo staff to take the faciling course.	food	
	Professional (QMRI personnel files on J 10:30 AM revealed assigned to prepare	s: tualified Mental Retar P) and review of four uly 1, 2009 at approx two of the four staff w e food for the home di andler's certification o	imately /ho was id not			08/30/09	

Health Regulation Administration

STATE FORM

PRINTED: 07/14/2009

FORM APPROVED **Health Regulation Administration** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED. A. BUILDING B. WING HFD03-134 07/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1321 EMERSON STREET NW COMP CARE II** WASHINGTON, DC 20011 **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 1090 Continued From page 1 1090 3504.1 HOUSEKEEPING 1090 The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable I 090 odors. The ceiling in the TV room has been repaired. This Statute is not met as evidenced by: Based on observation and interview, the facility The facility's maintenance failed to ensure the integrity of the physical team will on a monthly basis environment as required by this section. conduct environmental audits The finding includes: of the facility to ensure that all maintenance issues are During the environmental inspection on June 30, resolved. 2009 at approximately 9:55 AM, the ceiling in the 08/30/09 " TV Room " appeared to be water damaged with parts of the plaster missing from the ceiling. I 095 A cabinet has been installed in 1 095 3504.6 HOUSEKEEPING 1095 the basement were all cleaning and caustic agents shall be Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach locked. Direct Support Staff of each resident. have been strongly advised to always lock up cleaning agents. This Statute is not met as evidenced by: The House Manager will on a Based on observation and staff interview, the facility failed to enact and enforce the necessary weekly basis conduct measures to ensure the proper storage of all environmental tour of the caustic agents. facility to ensure that staff are adhering to keeping all The finding includes: cleaning detergents and caustic During the environmental observation and agents out of the reach of the interview with the Residential Director (RD) on

July 1, 2009 at approximately 11:59 AM, cleaning

and caustic agents (i.e. clorox, pine sol and

clients.

08/30/09

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-134 07/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW **COMP CARE II** WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) **PRÉFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **TAG** DEFICIENCY) 1095 Continued From page 2 1095 laundry detergent) were observed being stored in the laundry room in the basement unlocked. 1206 3509.6 PERSONNEL POLICIES 1206 Each employee, prior to employment and annually thereafter, shall provide a physician 's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure each staff and I 206 consultant had a current health certificate for Staff #11, the nutritionist, and three out of twenty-six files reviewed. the Director of Nursing have been requested to provide The findings includes: current health certificates by Interview with the Qualified Mental Retardation August 5, 2009. Professional (QMRP) and review of thirteen (13) employee records on July 1, 2009 at The Assistant Administrator approximately 9:30 AM revealed one (1) of the shall on a monthly basis thirteen staff records reviewed was without a current health certificate. (Staff #11) conduct audits of personnel records and consultants to Additionally, further interview with the QMRP on ensure that all required the same day at 11:25 am and the review of documents/certifications are thirteen (13) consultant records revealed, two (2) current. consultants (i.e. Director of Nursing and the nutritionist) were noted not to have current health 08/30/09 certifications. 1222 3510.3 STAFF TRAINING 1222

Health Regulation Administration

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-134 07/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1321 EMERSON STREET NW** COMP CARE II WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 1222 Continued From page 3 1222 There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that staff received ongoing training that enable them to perform their duties effectively, efficiently and competently for three of the three resident's in the sample. (Residents #1, and #3) The findings include: 1. The facility failed to ensure staff were trained to effectively document Resident #1's exercise I 222.1 objectives data in accordance with his Individual Cross Reference W252. Program Plan (IPP). (See Federal Deficiency Report Citation W252) 2. The facility failed to ensure that all staff who provide direct support to Resident #3 was trained in Crisis Prevention Techniques in accordance with his behavior support plan. On June 30, 2009 at approximately 11:15 AM. interview with the day program case manager revealed Resident #3 was sent home from the day program on May 27, 2009 for throwing a chair twice in his classroom. According to the case manager this was not a new behavior. Further interview with the day program coordinator revealed that on June 29, 2009 Resident #3 threw a chair on three separate occasions and physically attacked the receptionist. The case manager further commented that on both of these days the resident was sent home from the day program. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on July 1, 2009

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[Resident #3] in another direction away from the

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING HFD03-134 07/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW COMP CARE II WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 1222 Continued From page 5 1222 person he is trying to follow. Only staff trained in the crisis prevention techniques approved by the DDS, may accompany him away from the area. 5. If [the resident] continues to be aggressive and is not amenable to redirection, then a preferred staff person should remain close to him, out of his arm's reach. Be ready to intervene as needed, if this is feasible at such a time. Only staff trained in the crisis prevention techniques approved by the DDS may use the least restrictive techniques and only those strategies that are necessary to ensure [Resident #3] safety and that of peers and staff." Review of the in-service training log on the same day at approximately 3:20 PM, did not evidence Crisis Intervention Techniques strategies training was provided to the residential staff and/or the day treatment staff who routinely work with Resident #3. At the time of survey, there was no evidence the facility had ensure the necessary training in the I 222.2 area of Crisis Prevention and Intervention Cross Reference W189.2. techniques in accordance with Resident #3's BSP to ensure his safety. 3. The facility failed to ensure that staff was effectively trained to document Resident #3's refusal of food in accordance with his mealtime protocol. On June 30, 2009 at approximately 5:19 PM. Resident #3 was offered his dinner which consisted of shredded beef, mash potatoes with gravy and broccoli. Resident #3 refused to eat his meal. Staff repeatedly ask him to come to the table to eat his food. He continued to refuse. Resident #3 repeatedly requested "cheese and

Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING HFD03-134 07/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW COMP CARE I ! WASHINGTON, DC 20011 **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F222 Continued From page 6 1222 hot dogs". The QMRP redirected him and informed him that he was not allowed to eat cheese and hot dogs. At approximately 5:26 PM staff was observed to give Resident #3 a cup of Jello Pudding to eat. Resident #3 took the pudding into the living room. sat on the couch and ate it. The staff commented, "We will wrap his food up and put it into the refrigerator and offer it to him later." On July 1, 2009 at 12:00 PM, the surveyor opened the microwave and found a plate of food with the same food items that were served the previous evening. Interview with the Residential Director (RD) confirmed that the plate of food in the microwave belonged to Resident #3. The RD stated that she would follow-up with the evening staff to find out why Resident #3 did not eat his dinner. Later interview on the same day with the RD at approximately 2:45 PM revealed, Resident #3 was provided a sandwich as a substitute. However, it could not be determine the type of sandwich that was provided. On the same day at 3:15 PM, review of Resident #3's mealtime protocol dated December 3, 2008 revealed, staff are to "document Resident #3's refusal to eat food presented and report to medical personnel and the QMRP of the residential facility". Review of the resident records did not evidence that staff documented the resident's continued refusal and the substitution provided. It should be noted that review of Resident #3's nutritional

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assessment dated December 29, 2008 failed to include a list of the resident's food preference

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07/01/2009

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NAME OF PROVIDER OR SUPPLIER

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STREET ADDRESS, CITY, STATE, ZIP CODE

1321 EMERSON STREET NW

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1 227	Continued From page 8		227						
	Retardation Professional (QMRP) and rev thirteen employee files on July 1, 2009 at approximately 9:49 AM revealed Staff #5 currently employed and was working without valid First Aid certification.	was							
1 375	3519.6 EMERGENCIES		375						
	Each GHMRP shall document each emergand enter the follow-up actions into the resperment record, which shall be made available for review by authorized individu	sident '							
	This Statute is not met as evidenced by: Based on staff interview and record review facility failed to ensure the timely investiga an injury of unknown origin for one of three sampled residents. (Resident #2)	ation of							
	The finding includes:								
	On July 1, 2009 at approximately 12:40 Plinterview and record review with the Regis Nurse (RN) at Resident #2's day program revealed a "Health Concern Communique was issued to the residential facility on Jur 2009. The HCC provided the following de	stered " (HCC) ne 4,	(00)						
2 	"O/E today we noticed his right foot latera had an open wound draining serosanguing percolate - area was cleaned with normal non-adhesive dry [guaze] applied/taped se [Resident #2] stated he 'fell the other day a home'."	eous saline & ecurely .							
	Interview with the facility's Qualified Menta Retardation Professional (QMRP) on July at 4:01 PM revealed he did not know how Resident #2 sustained the injury and did n initiate an investigation to determine the po	1, 2009 ot							

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interview and record review with the Registered

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I 379	Continued From pa	ge 10		1 379				
	revealed a "Health of was issued to the real 2009. The HCC profuse." "O/E today we notice had an open wound percolate - area was non-adhesive dry [g	dent #2's day program Concern Communiquesidential facility on Jovided the following of ed his right foot later draining serosanguits cleaned with normal uaze] applied/taped	ue" (HCC) une 4, details: al area neous al saline & securely.					
	He [Resident #2] sta home'."	ated he 'fell the other	day at					
	Retardation Profess at 4:00 PM revealed Resident #2 sustain		ly 1, 2009 w er t was not					
	Record review at the same day at approx document entitled "I Reporting Procedure DDS" provided guidunusual incidents. "Section A - Life threfor the following interests."	imately 4:10 PM, rev ncident Handling and es for Persons Serve ance on how to man The information outling eatening Situation" p	ealed a ded by age ned in					
	" If an injury is NOT aid, as necessary, the Section C describes complete an incident	nen proceed to section that the agency must be the section to the	on C."					
	At the time of the surensure an incident rethe agency administ Resident #2's injury day program.	eport was generated rator and other offici	to notify als of		I 379 Cross reference W149			

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l 401	Continued From pa	ge 11		l 401				
I 401	3520.3 PROFESSIONS	ON SERVICES: GEN	NERAL	I 401				
	Professional service and evaluation, includevelopmental level services, and service deterioration or furth resident.	uding identification o ls and needs, treatm es designed to preve	f ent ent					
	This Statute is not read the GHMRP failed to services that include designed to prevent of function by the represidents in the same Resident #3)	to provide profession and treatment services deterioration or furth sident, for two of thre	nal s ner loss ee					
	The findings include	:						
	Observation of the 30, 2009 at approxin Licensed Practical Nadminister Nasonex at the time of the me	nately 7:55 AM revea lurse #1 (LPN) did no nasal spray to Resiq	aled ot					
	Review of the June, Administration Reco orders (POS) dated at approximately 8:2 was ordered Nasone in each nostril every	rd (MAR) and physic June, 2009 on June 5 AM revealed Resic ex nasal spray; two(2	30, 2009 dent #3					
	In an interview with L approximately 8:35 A Resident #3 was to h Nasonex nasal spray nostril every day.	AM, it was acknowled have been administe	iged red	i				
	There was no eviden	ice that all drugs wei	re					

PRINTED: 07/14/2009 FORM APPROVED **Health Regulation Administration** STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING HFD03-134 07/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1321 EMERSON STREET NW** COMP CARE II **WASHINGTON, DC 20011** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) I 401 Continued From page 12 1401 administered without error. [Note: LPN #1 administered Resident #3's Nasonex nasal spray; two(2) sprays in each nostril on June 30, 2009 at approximately 8:40 AM after the surveyor revealed the medication error.1 2. Observation of the medication pass on June 30, 2009 at approximately 8:20 AM revealed that LPN #1 did not administer Nasonex nasal spray to Resident #1 at the time of the medication pass. Review of the MAR dated June, 2009 and the POS dated June, 2009 on June 30, 2009 at approximately 8:27 AM revealed Resident #1 was ordered Nasonex nasal spray; two(2) sprays in

I 401 (1 & 2)

Cross reference W369.1

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error.

each nostril every day.

administered without error.

1500 3523.1 RESIDENT'S RIGHTS

nostril every day.

In an interview with LPN #1 on June 30, 2009 at approximately 8:36 AM, it was acknowledged Resident #1 was to have been administered Nasonex nasal spray; two(2) sprays in each

There was no evidence that all drugs were

[Note: LPN #1 administered Resident #1's Nasonex nasal spray: two(2) sprays in each nostril on June 30, 2009 at approximately 8:42 AM after the surveyor revealed the medication

Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Adm.

Health Regulation Administration (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING_ 07/01/2009 HFD03-134 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1321 EMERSON STREET NW WASHINGTON, DC 20011 **COMP CARE II**

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	thirteen (13) direct care staff files reviewe (Staff #6, #8, and #9)	d.					
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